Welcome

Patient's Name _____

Nickname _____

Parent's/Guardian's Name _____

DENTAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist?……YES NO
2. If not, how long since last visit? _____
3. Where any x-rays taken?……...YES NO
4. Does your child eat sweets, such as candy or soda pop? ……..YES NO
5. When does your child brush his/her teeth?
   ( ) Upon Arising ( ) After eating any food
   ( ) Right after meals ( ) Before going to bed
6. How does your child receive Fluoride?
   ( ) Community Water ( ) Well Water
   ( ) Fluoride drops or tablets ( ) Fluoride rinse or gel
8. Have any cavities been noted in the past? ……YES NO
9. Have there been any injuries to teeth?……YES NO
   If so, describe _____
10. Has your child had any problems with dental treatment in the past?
    ……..YES NO
11. Has your child ever received a local anesthetic? ……...YES NO

MEDICAL HISTORY

1. Does your child have health problems?……YES NO
2. Is your child under care of a physician? ……YES NO
   If yes, since when and why? _____
3. Name and phone no. of physician _____
4. Is your child receiving any medication? ……YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? .YES NO
6. Is your child allergic or sensitive to any metals or latex? …….YES NO
7. Does your child have other allergies? ……YES NO
8. Has your child had any serious illness? ……YES NO
   When? _____
9. Has your child ever had surgery? ……YES NO
10. Does your child have a heart murmur? ……YES NO
11. Does your child experience severe or prolonged bleeding? ….YES NO
12. Does your child have AIDS or has tested HIV positive? …….YES NO
13. Has your child tested positive for hepatitis? ……YES NO
12. Is your child subject to nervous disorders? ……..YES NO
    ( ) Fainting ( ) Seizures
    ( ) Dizziness ( ) Behavioral/Learning Problems
13. Does your child have frequent headaches? ……..YES NO
14. Has your child had a history of: (Circle appropriate responses)
    diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

CHILD DENTAL MEDICAL HISTORY